Thank you for choosing Gaston Dental Associates! To help us meet your entire dental healthcare needs, please fill out these forms *completely*. If you need any assistance or have any questions, please ask and we'll be happy to help!

Referrals are important to us! Please tell us how you heard about us:

☐ Google ☐ Direct Mailer ☐ Insurance ☐ Facebook ☐ Twitter ☐ Other_____

If referred by a patient/relative, whom may we thank for referring you: _____
How do you prefer to be contacted? ☐ Cell phone ☐ Home phone ☐ Email ☐ Other_____

Patient Information

Name: _____ Preferred Name: _____ Sex: M F

Address: _____ Home Phone: _____

City: _____ State:_____ Zip: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Work Phone: _____

Email: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or Parent/Guardian Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Name of person responsible for account: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Relationship to Patient: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ DOB: _____

Insurance Company: _____Name of Employer: _____

Policy/ID Number: _____ Group Number: _____ Insurance Phone Number: _____

Patient/Responsible Party Signature: _____ Date: _____

816 East Franklin Blvd
Gastonia, NC 28054
704.396.6166
www.gastondentalassociates.com

Dismissal Policy:

When patients no show, cancel at the last minute, or show up late for their appointments, it greatly effects our schedule, as well as other patients' appointments. Due to this, we ***require a 24 hour notice*** to cancel and/or reschedule an appointment.

In the event that you have more than three broken appointments, late cancellations, or frequently show up late for your appointment, you will be dismissed from our practice. Leaving a voicemail to cancel within 24 hours is considered a late cancellation.

We also ask that you abide by the following rules while in our office so that we can serve your dental needs in the best way possible:

-There is no food or drink in the waiting area.

-Cell phones are not to be used in our office. Please step outside if you need to make a call.

-If you are the parent or guardian of a child under the age of 18, you MUST remain in the office until all treatment is completed on the child.

-If you are more than 15 minutes late for an appointment, you may have to reschedule your appointment. When you are late, it counts towards our dismissal policy.

I understand my responsibilities as outlined above and will abide by them.

Patient's Name: _____ Date: _____

Patient or Guardian's Signature: _____

Please read the following information *carefully* to minimize billing and insurance problems:

- An insurance card should be presented at time of service. If eligibility cannot be confirmed prior to being seen, you will be responsible for all charges until the billing office has received complete, current and accurate insurance information.
- Your insurance company does not guarantee any payment of services until the claim we submit has been received and reviewed. Therefore, **your portion of services performed in this office is only an ESTIMATE and due payable at the time of service.**
- Dental insurance has deductible and yearly maximums. Please familiarize yourself with your plan's specifics and notify us as soon as possible when any changes are made.
- **Charges that are denied by your insurance company will be transferred to your responsibility.** If you have questions, regarding this action, you should contact your employer or the insurance company directly for an explanation. Covered procedures differ from plan to plan and it is impossible for us to know the particulars of each plan. Once the responsibility has been transferred, our normal collection policies will be enforced. Thank you.
- Our office requires at least a **24 hour** notice for cancellation of appointments. If you are unable to give sufficient notice, your appointment may not be rescheduled.

I understand my responsibilities as outlined above and will abide by them.

_____ _____

Patient or Guardian's Signature Date

Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name: _____

Address: _____

_____

I have read and understand the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For office use only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
  _____
- ☐ Other: _____

Prepared by: _____

Signature: _____

Date: _____